

is sudden and simultaneous, a lesion of the crus may be presumed. * * *

DISEASES OF THE TUBERCULA QUADRIGEMINA are rare in medical literature, and only a few observations could be utilized for fixing the question as to local diagnosis. From these, the conclusion was deduced that disease of the anterior pair almost always is accompanied with impairment or loss of vision. This symptom is not to be referred to the optic lobes necessarily, unless, with non-reacting pupils, it be of sudden appearance, and accompanied by other symptoms of local disease, and absence of posterior ophthalmic symptoms.

Lesions of the posterior are accompanied (not invariably) with paralysis of (certain branches?) the motor oculi, but the presence or absence of this symptom is not sufficient for diagnosis. The paralysis may be bilateral with an unilateral lesion, and in this case, if unattended with paralysis of the members, it suggests the optic lobes as the part involved. Disorders of equilibrium and co-ordination like those accompanying cerebellar disease, are also sometimes observed. * * *

LESIONS OF THE OPTIC THALAMI exhibit the following symptoms:

1 and 2. An absolute diagnosis of isolated lesions is impossible at present, except under specially favourable circumstances, for the symptoms are ambiguous.

3. Motor paralysis does not support the diagnosis of thalamic lesions, and when it exists we must assume the implication of other parts, even though the thalamus be the part principally involved.

4 and 5. The same is true of anæsthesia. If disturbances of sensibility, dependent on injury of that portion of the inner capsule which passes the thalamus, should occur, they might enable us to say that the lesion is situated in or near the thalamus, but they would not establish the existence of thalamic disease. The same is true of vaso-motor tracts.

6 and 7. Though disturbances of vision may occur, whether in the form of contralateral amblyopia or homonymous hemiopia, cannot be stated, they are not of great diagnostic value since they also appear with lesions of other localities. The same estimate may be placed on

the diagnostic value of hemichorea, athetosis and unilateral tremour.

8, 9, and 10. Increase or diminution of reflex excitability is not indicative of thalamic lesions, but, possibly, disturbances of the muscular sense and disorders of psycho-motor actions are.

In conclusion, thalamic lesions may be reasonably conjectured under specially favourable conditions, but they cannot be diagnosed with certainty. * * *

CORPORA STRIATA.—As most cerebral hemorrhages occur in these parts, the symptoms of them coincide pretty well with those of typical hemiplegia. Of late years the anatomy of the brain has been revised, and the corpora striata have been shown to consist of several physiologically distinct parts. More exact localization is now possible than was formerly the case. Our author studies separately lesions of six different localities in the striated bodies, viz.: Those of the lenticular nucleus; those of the caudate nucleus; those of the anterior portion of the internal capsule; those involving either the lenticular or caudate nucleus, with, at the same time, the anterior portion of the internal capsule; those of the posterior portion of the internal capsule; and those affecting only the lenticular nucleus or the optic thalamus, with the posterior portion of the internal capsule or the adjoining part of the radiant crown of Reil. His conclusions are as follows:

1 and 2. Destroying lesions of the corpus striatum may produce contralateral motor, sensory and vaso-motor paralysis, and if they be not extremely small they regularly cause motor hemiplegia.

3. If the lenticular or caudate nucleus alone be involved, the hemiplegia may gradually disappear; but if the internal capsule be affected, either alone or with the gray nuclei, the paralysis is permanent. In these permanent paralyses (*i. e.*, in lesions of the internal capsule) secondary contractures frequently occur.

4. The motor hemiplegia from stationary destroying lesions affects, regularly, both extremities of one side and the inferior branch of the facial, the muscles of the trunk usually being paretic. The hypoglossal nerve is either wholly unaffected or only affected in the beginning; it is not often permanently involved. In rare